DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-0258

November 15, 2000

TO: All County Welfare Directors
All County Administrative Offices
All County Medi-Cal program Specialists/Liaisons
All Public Health Directors
All Mental Health Directors

Letter No.: 00-56

PETTIT V. BONTA´ - PERSONAL CARE DEDUCTION FOR PERSONS IN LICENSED BOARD AND CARE FACILITIES

The purpose of this letter is to give instructions for implementing the decision reached in the Pettit v. Bontá lawsuit. The court found the Medi-Cal program needed to allow persons in licensed board and care residential facilities the ability to apply incurred expenses for personal care services to their share of cost (SOC).

Counties need to identify applicants/beneficiaries with a SOC living in Adult Residential facilities, Residential Facilities for the Chronically ILL, and Residential Facilities for the Elderly. Effective April 1, 2000, individuals in licensed board and care residential facility are to be allowed a standard $315 personal care services income deduction in lieu of the excess maintenance need deduction for residential care and support indicated in Title 22, California Code of Regulations 50515(a)(3). If the excess maintenance need deduction allows for a lower SOC than the standard $315, then the excess maintenance need deduction is to be used instead.

For those individuals determined to have a lower SOC for any prior month(s), the "SOC Case Make-up Inquiry Request" (SOCR) screen of the "Medi-Cal Eligibility Data System" (MEDS) needs to be checked to determine whether or not any of the SOC was met.

- For those months where none of the SOC was met, change the SOC to the new amount and advise beneficiary to bill for services as appropriate.

- For those months where part or of the SOC was met, follow instruction described In Article 12C of the Medi-Cal Procedures Manual for "Processing Cases When SOC has Been Reduced Retroactively". See attachment #1, updated draft of Article 12C.

The licensed board and care facilities are being requested to post a notice concerning the deduction for personal care services. This notice will instruct individuals in licensed board and care facilities to contact their county Eligibility Worker if they have a SOC or had a SOC for any month back to April 2000 (see Attachment #2). Counties must make this change when it comes to their attention that the individual is in licensed board and care and no later than the next reinvestigation. Counties are encouraged to make this change as soon as possible in order to avoid additional prior month adjustments. In order to use the SOCR screen, cases need to be reviewed by April 30, 2001. For cases reviewed after April 30, 2001, the county will need to call Ana Ramirez, the Medi-Cal Eligibility Branch Confidentiality/MEDS Analyst at (916) 657-1401 or send an e-mail to aramirez@dhs.ca.gov to determine whether or not the beneficiary met any medical expenses for months going back more than 12 months.

The State has a listing of the licensed board and care residential facilities. Counties may find it useful to have a copy of this listing to help identify persons living in these facilities. Any county wanting a copy of the residential facilities in their county or have any questions on this letter should contact Mr. Chet Heine at (916) 657-0837.

Sincerely,

ORIGINAL SIGNED BY
RICHARD BRANTINGHAM for

Glenda Arellano, Acting Chief
Medi-Cal Eligibility Branch

Enclosure

MANUAL LETTER NO.

12 C – PROCESSING CASES WHEN A SHARE-OF-COST (SOC) HAS BEEN REDUCED RETROACTIVELY

A. Background

California Administrative Code (CAC), Title 22, Section 50653.3(c), discuss the need to make adjustments when a person has been determined to have a lower Medi-Cal SOC for a given month(s) than was originally computed. Welfare and Institutions Code Paragraph 14019.3 speaks to provider return of payments for services covered by Medi-Cal. Persons determined to be entitled to a lower share of cost have the option of:

1. Having future SOC amounts adjusted by the county; or

2. Adjusting with providers, the amounts obligated or paid to those providers to meet the overstated portion of the original SOC.

If an individual is seeking an adjustment of a future SOC and transfers to another county prior to receiving the full adjustment, the former county of responsibility must inform the new county of the adjustment amount that is still due.

Beneficiaries whose future SOC is zero before an adjustment is applied, must be advised that the only recourse is to seek reimbursement from the provider. In any situation where a beneficiary chooses to seek reimbursement from a provider, it must first be determined whether the provider has billed or submitted a SOC clearance transaction for the month which reimbursement is requested. This may be determined by reviewing the Medi-Cal Eligibility Data System (MEDS), SOC Case Make-Up inquiry Request (SOCR) screen for the appropriate month. If the SOC shown on SOCR for the appropriate month is the same as the county's computed SOC then a provider has not submitted a SOC clearance transaction. If the remaining SOC is less than the SOC or zero then a Medi-Cal provider has submitted one or more SOC clearance transactions. The SOC for back months cannot be reduced on MEDS to an amount lower than the amount of clearance transactions posted. For example, if the SOC is $100.00 and a provider has submitted a $25.00 SOC clearance transaction for medical services rendered, the SOC cannot be reduced to an amount lower than $25.00. Therefore, if the SOC is being reduced to $40.00 (any amount below $100.00), this new SOC amount would be input to MEDS and no SOC adjustment is necessary. When the SOCR screen shows none of the SOC being met, the lower SOC can be input into the MEDS system and no SOC adjustment is necessary.

SOCR information only goes back 12 months. If the month of overcharge is for a over 12 months from date of processing and not on SOCR, call the Medi-Cal Eligibility Branch Confidentiality/MEDS Analyst at (916) 657-1401 or send an e-mail to aramirez@dhs.ca.gov.

Prior to seeking reimbursement from the provider, beneficiaries shall be instructed by the county to give the provider a "Share of Cost Medi-Cal Provider Letter" (MC 1054 -- See Attachment I) so that the provider may bill the Medi-Cal program and reimburse the client the appropriate share-of-cost amount. The "Share of Cost Medi-Cal Provider Letter" explains the reimbursement and billing procedures and the recomputation of the SOC.

B. Case Situations

The following procedures describe the adjustment process and the different methods for working with various case situations in recomputing the SOC.

Adjustment of SOC Amount

Case Situation 1 -- Beneficiary was determined eligible for July with a SOC and met the SOC (determined by viewing SOCR screen). It is later determined that the SOC should have been lower. Beneficiary requests adjustment of future SOC amounts.

Case Processing Steps

a. The county shall recompute the SOC for the overstated SOC month(s). Prepare a new MC 176 M for the month of July. The difference between the original and recomputed SOC is the amount of the adjustment.

b. On the MC 176M for September (the future months in which the SOC is to be adjusted), enter the SOC adjustment for the month of July on line 15. Subtract line 15 from line 14 and enter in line 16. Line 16 is the SOC for September which reflects the July overcharge. If the amount of the adjustment is greater than the September SOC amount, the beneficiary is not required to meet a SOC for that month. If necessary, repeat this process for subsequent months until the entire adjustment is made.

Case Situation 2 -- Beneficiary was determined eligible for October 1999 with a SOC and met part of the SOC for this month. It is later determined that the SOC should have been lower. Beneficiary requests adjustment of the future SOC.

a. View SOCR screen for month to determine amount of SOC that was met.

b. If it is determined that a provider submitted SOC clearances for more than the beneficiary's recomputed SOC, a SOC adjustment is needed. The difference between the amount cleared and the recomputed SOC will be the amount to be adjusted (e.g., client's original SOC is $100.00, beneficiary paid $75.00; the recomputed SOC is $50.00, the amount to be adjusted for future month is $25.00).

c. Process case according to steps listed for items a-b in Case Situation 1.

d. If the amount cleared for the month of October is less than the recomputed SOC, no adjustment is necessary. The change in the SOC needs to be posted to MEDS if being processed within a year from the month of the overstated SOC.

Provider Reimbursement of SOC

Case Situation 3 -- Beneficiary was determined eligible for November 1999 with a SOC and met the SOC. A recomputation indicates the SOC should have been zero. Beneficiary wants a reimbursement of the SOC amount paid to the provider(s).

a. The county shall recompute the SOC for the overstated SOC month(s). Prepare a new MC 176 M for the month of November.

b. The county shall also prepare an MC 1054 explaining the SOC Adjustment and give or mail it to the beneficiary.

c. The client gives the MC 1054 to the provider (s).

d. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 1054 with their Medi-Cal billing.

Case Situation 4 -- Beneficiary was determined eligible for September with a SOC and met the SOC. A recomputation indicates the SOC should have been lower. Beneficiary wants reimbursement for the excess SOC amount paid. The provider(s) billed Medi-Cal for a portion of the SOC.

a. The county shall recompute the SOC for the overstated SOC month(s). Prepare a new MC 176 M for the month of September.

b. The county prepares an MC 1054 for the beneficiary.

c. The client submits the MC 1054 to the provider(s).

d. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 1054 with their Medi-Cal billing.

Case Situation 5 -- Beneficiary had a SOC for the previous month of April of $100.00 and according to the MEDS SOCR screen, met $50.00 of this SOC. It was later determined that the SOC should have been $75.00.

a. In this situation there is no SOC adjustment.

b. The MEDS SOC for April needs to be changed to $75.00 if processed within one year from the overstated SOC month.

Case Situation 6 -- Beneficiary had a SOC for the previous month of May in the amount of $200.00. The SOCR screen indicates that $150.00 of the SOC was met. It has been determined that the SOC should be $100.00.

a. Change the SOC on MEDS to $150.00 (MEDS will not accept a change below the amount of services that has already been credited towards the SOC).

b. County prepares an MC 1054 showing the original SOC as $150.00 and the revised amount as $100.00 and gives or sends it to the beneficiary.

c. The beneficiary submits the MC 1054 to the provider(s).

d. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 1054 with their Medi-Cal billing.

Case Situation 7 -- Beneficiary had a SOC for a month that was over a year ago in the amount of $200.00 and it has been determined that the SOC should have been only $100.00.

a. To determine whether or not any of the SOC was met, contact the Medi-Cal Eligibility Branch (MEB) MEDS Confidential Analyst at (916) 657-1401 or e-mail at aramirez@dhs.ca.gov/, if beneficiary met any or all or the SOC. If none of the SOC was met, no further action is needed. If all or an amount over the new SOC was met, proceed to the next steps.

b. If MEB determined that the provider(s) submitted SOC clearance transmittals in the amount or $175.00 a provider rebilling is needed. County prepares an "Letter of Authorization" (MC 180 – See Attachment II) and an MC 1054 which shows the original SOC as $200.00 and the revised SOC as $100.00. If only $100.00 or less of the SOC had been met, there would not be a need to complete the MC 1054 or the MC 180 as the beneficiary would not be entitled to a refund from the provider(s).

c. The provider(s) bills Medi-Cal and reimburses the beneficiary after payment from Medi-Cal is received. The provider needs to submit a copy of the MC 180 and the MC 1054 with their Medi-Cal billing.

State of California—Health and Human Services Agency

Department of Health Services

SHARE-OF-COST MEDI-CAL PROVIDER LETTER

(COUNTY STAMP)

Provider name and address

Notice date: _____

Case name: _____

Case number: _____

EW name: _____

EW number: _____

EW address: _____

_____

EW telephone number: _____

_____ (Beneficiary's name), _____ (Beneficiary's Social Security number), was determined eligible for Medi-Cal with a share of cost that has been changed for the following months:

Month/Year						
Original SOC						
Revised SOC						
Month/Year						
Original SOC						
Revised SOC						

The California Code of Regulations, Title 22, Section 51471.1, requires providers to cooperate with the Department of Health Services in making reimbursements to the beneficiaries for Medi-Cal program underpayments. The Welfare and Institutions Code, Section 14019.3 and the regulations further require that the provider accept an underpayment adjustment from the Medi-Cal program for such beneficiaries and reimburse such beneficiaries the full amount of that adjustment, up to the actual amount received in payment from the beneficiary for medical services in question.

You must do one of the following if the beneficiary paid or obligated to pay an original share of cost (SOC) amount to you.

If you...	And the share of cost...	Then you...
billed Medi-Cal for the balance of the charges,	has been reduced or is now zero,	may bill the program for the difference between the original share of cost and the adjusted share of cost. Submit a Claims Inquiry Form (CIF) with this MC 1054 attached. ***Note: Do not submit a new claim. It will be considered a duplicate claim and payment will be denied.***
did not bill Medi-Cal because the charges equaled or were less than the original SOC,	has been reduced,	may bill the program if the services you rendered now exceed the adjusted SOC. Submit a claim with the adjusted SOC amount in the "Patient's Share of Cost" field, and attach this MC 1054.
	is now zero,	may bill the program for the services you rendered. Submit a claim with a zero (0) in the "Patient's Share of Cost" field, and attach this MC 1054 form.

Once the CIF is approved and payment is received, you are required to reimburse the beneficiary any share of cost paid for the services, or eliminate/adjust the outstanding share of cost obligated for the services billed.

MC 1054 (10/99)

THE MOTTON TAPE OF THIS DOCUMENT CHANGES COLOR GRADUALLY AND EVENLY FROM DARK TO LIGHT WITH DARKER AREAS BOTH TOP AND BOTTOM.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES

ELIGIBILITY LETTER OF AUTHORIZATION

Document Number 403406

Issuance Date of MC 180: _____ Date

** Provider Name: _____

** Provider No.: _____

Beneficiary's Name, Address, City, State and Zip

Issuing County:
SSN / Pseudo No.:
County I.D.:
Date of Approval (SSI only):
* Worker's Name:
* Worker's Number:
* Worker's Telephone #:
Other Health Coverage (Code):

MEDI-CAL BILLING FOR:

Mo. Yr.	Mo. Yr.	Mo. Yr.	Mo. Yr.
Mo. Yr.	Mo. Yr.	Mo. Yr.	Mo. Yr.
Mo. Yr.	Mo. Yr.	Mo. Yr.	Mo. Yr.

This original numbered MC-180 is approval for Medi-Cal providers to bill services provided to you during the above referenced months. An MC-180 is being issued in accordance with Title 22, California Code of Regulations (CCR) Section 50746. This regulation permits county welfare departments to issue documentation of eligibility which can be used by beneficiaries for periods more than one year after the month of service as a result of one of the following reasons:

1. ☐ SSI/SSP eligibility was approved for a retroactive period but cards were not issued by the State Department of Health Services.
2. ☐ A court order requires that Medi-Cal be issued.
3. ☐ A State Hearing or other administrative hearing decision requires that Medi-Cal be provided.
4. ☐ The State Department of Health Services requests that Medi-Cal be issued. (Original signature of an authorized DHS staff person: _____).
5. ☐ An Administrative Error has occurred.
(Description) _____

Please immediately give your doctor or other medical provider this form for the applicable month(s)/year(s) of service. Providers do not need to submit a Medi-Cal proof of eligibility label with their claims when using this MC-180.

If you were provided services by more than one doctor or provider, please contact your local welfare office immediately to obtain additional original form(s).

INSTRUCTIONS TO PROVIDER
Submit this form, along with the claim(s), to:

EDS Federal Corporation
Attention: Over-One-Year-Unit
P.O. Box 13029
Sacramento, CA 95813-4029

(Original Signature of Authorized County Administrative Staff)

* This information is not needed when eligibility is established by the Social Security Administration.
** Optional

MC 180 (1/89)

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
GRAY DAVIS, *Governor*
DEPARTMENT OF HEALTH SERVICES

IMPORTANT MEDI-CAL NOTICE FOR PERSONS IN BOARD AND CARE

In a recent court decision it was determined that Medi-Cal beneficiaries living in licensed board and care are entitled to an income deduction for personal care services. If you reside in any of the following licensed board and care facilities and have a share of cost or had a share of cost for any month from April 2000 to the current month, you should contact your county Eligibility Worker:

- Adult Residential facility
- Residential Facility for the Chronically ILL or a
- Residential Facility for the Elderly

Note: This deduction for personal care services may or may not change an individual's Medi-Cal share of cost.